Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-99-4470-01

MFDR Date Received
August 13, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the per diem rates contained in the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas. Therefore the carrier's adoption of the same are likewise void and unenforceable... The carrier simply adopted the per diem rates and asserted the payment was fair and reasonable with no substantiating support or evidence for the same… As a result the holding of the Supreme Court, the carrier is obligated to pay the full charges, and is estopped from asserting void rates are fair and reasonable… the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law.'"

Amount in Dispute: $6,731.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills were properly paid pursuant to the per diem rates and other provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline… While the Guideline was invalidates as a TWCC rule based on procedural error in its adoption, the per diem rates and methodology of the Guideline are a valid measure of fair and reasonable hospital fee reimbursement for acute care inpatient treatment."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 1997 to August 21, 1997	Inpatient Hospital Services	$6,731.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, provides for the fair and reasonable reimbursement of services not identified in an established fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – REDUCTION ACCORDING TO FEE GUIDELINES
   - M – Reduced to fair and reasonable

Findings

1. This dispute was received by the Division on August 13, 1998. The disputed dates of service are from August 19, 1997 to August 21, 1997. The dispute was received within one year from the dates of service in dispute. The Division concludes that the dispute was submitted in accordance with the timely filing requirements of 28 Texas Administrative Code §133.305(a); therefore, these services will be considered in this review
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401, effective August 1, 1997, Volume 22 *Texas Register*, page 6264. Review of the submitted documentation finds that the length of stay was 2 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $2,236.00. This amount is recommended.
3. Additionally, per §134.401(c)(4)(B)(i), magnetic resonance imaging (MRI) services indicated by revenue codes 610-619 shall be reimbursed at a fair and reasonable rate. 28 Texas Administrative Code §134.1(f), effective October 7, 1991, Volume 16 *Texas Register*, page 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission." §134.1(f) references the former Texas Workers' Compensation Act section 8.21 which was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle." The requestor billed MRI services under revenue code 612. Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated for the MRI services.
   - The requestor's position statement states that "the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law.'"
   - The Division notes that former Division rule at 28 Texas Administrative Code §42.110(b)(2) is not applicable to the services in dispute. The 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues for the MRI services in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, Volume 125 *South Western Reporter Third* page 96 (Texas Appeals – Austin, 2003, petition for review denied).
   - The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.

- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for MRI services is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the MRI services in dispute. Additional payment cannot be recommended.

4. The total recommended payment for the services in dispute is $2,236.00. This amount less the amount previously paid by the insurance carrier of $2,967.75 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	May 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.